Canada: Healthcare Financing and Delivery in Ontario and Quebec

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Summary

U.S. medical equipment and technology suppliers contemplating entering Canada's two major healthcare markets of Ontario and Quebec should become familiar with the provincial Medicare health insurance programs under Canada's Health Act that insure almost all Canadian residents through income tax revenues, and consider appointing an agent or distributor in Canada to best follow new procurement and marketing opportunities rather than trying to sell to the Canadian market directly from the United States.

Medicare – Canada's Universal National Health Insurance

In 2004, Canadians spent an estimated CDN $130 billion (approximately US $110 billion at US $.85 per CDN $1) on health care. The public sector share of this amount was CDN $91.1 billion, approximately 70 percent. Three levels of government finance public sector health spending through tax revenues: municipal governments, provincial and territorial governments, and the federal government. Most of the financing comes from provincial and territorial government coffers, part of which is financed by transfers from the federal government. The largest component of public sector spending, hospitals, accounts for approximately 30 percent of the whole, or about CDN $39 billion. Private sector spending accounts for 30 percent, with the largest component being prescription drugs, accounting for 16 percent of the whole, or about CDN $21 billion.

In 2004, federal and provincial ministers approved a ten-year plan that will provide for the infusion of CDN $41.3 billion into the system, most of it through the Canada Health Transfer. The plan identifies several shared priority areas including reduced wait times, pharmacare, home care and primary health care.

Healthcare delivery and financing in Canada are based on the principle that all residents should receive healthcare based on their medical needs regardless of their ability to pay. Canada's Medicare, funded from income tax revenues, provides first-dollar coverage for medically necessary health services.

The federal Canada Health Act governs the Canadian public health system by ensuring that all eligible persons in the country have reasonable access to covered healthcare services paid by Medicare. Two other provisions of the Canada Health Act ban user charges and other forms of cost sharing such as coinsurance and co-payments. The primary role of the federal government is to establish and administer uniform national principles for the health care system through the Canada Health Act; to assist the financing of provincial/territorial health care services through fiscal transfers; to deliver health care services to specific groups (e.g. First Nations and Inuit) and to provide other health-related functions such as health protection programs and health research.

The administration and delivery of health care services are, however, the responsibility of each province and territory. Health care legislation and its enforcement in Canada vary from province to province. While some provinces currently have no additional legislation, other provinces have provincial health legislation that reinforces the Canada Health Act.

Provincial health care services include insured primary health care, such as services of doctors, nurses and other health professionals, and care in hospitals. Additionally, the provinces and territories provide a limited number of persons with supplementary health benefits not covered by the Act, such as prescription drug coverage and dental and vision care. Canada is perhaps the only major developed country to have full public management of hospital resources, which are operated by community boards, voluntary organizations and municipalities.

Canada is the only country to have outlawed, through provincial and territorial legislation, private health insurance that would parallel the national healthcare system. Rather, private health insurance in Canada is only supplemental to Medicare, covering services and healthcare products not explicitly offered by the public scheme. The vast majority of doctors and other healthcare providers that are part of the Medicare system are allowed only to bill the provincial or territorial Medicare for medical care listed in the Medicare schedules, and cannot bill patients. Patients are prohibited from making out-of-pocket payments to receive expedited care, and in principle rich and poor, famous athlete and ordinary citizen, the well connected and the anonymous, must wait their turn for medical care according to their medical necessity. In practice, however, there have been criticisms of this system for the long wait times to get an appointment with a doctor, for diagnostic tests, for referrals to a specialist and for surgery, and for some well-publicized queue-jumping by some professional athletes and politicians. In addition, some doctors have opted completely out of the system, and bill their patients directly. However, while such parallel private healthcare outside of Medicare has been allowed, parallel private health insurance, stated above, has not. So private patients must pay the full charges out of their own pockets.

However, in June 2005, the Supreme Court of Canada overturned a Quebec law preventing people from purchasing primary private health insurance to cover medical care offered by the public Medicare system. The Quebec government obtained a stay (delay) of 18 months before the decision takes effect, to allow the Quebec Government to develop a plan for implementing changes in the Medicare system in an orderly fashion. The Quebec Government has not yet made changes to its laws or regulations to conform with the decision. While the ruling applies only to the Province of Quebec, it is widely expected to fundamentally change the way healthcare is delivered and financed across the country.

Medicare and Healthcare Delivery in Ontario

Ontario is Canada's most populous province, with 12.5 million inhabitants, representing about 40 percent of Canada's population. Ontario's public and private health spending in 2005 is estimated to have been approximately CDN $4,500 per person. Healthcare accounted for about 40 percent of Ontario's budget in 2001-2002.

The Administration of Public Healthcare Delivery in Ontario

Tax-paid health care in Ontario is universally available to all residents at no separate cost to the patient. Administered by the Ontario Ministry of Health and Long-Term Care, the Ontario Health Insurance Plan (OHIP) covers the full cost of all necessary diagnostic and treatment medical services including physician examinations, medical testing, emergency care, hospital care and emergency dental care. Further information about the OHIP is available at:
http://www.health.gov.on.ca/english/public/program/ohip/ohip_mn.html

Through the Ontario Drug Benefit Program available primarily to aged, infirm or low-income Ontario residents, the Ministry of Health and Long-term Care also covers most of the cost of 3,000 prescription

drugs products listed in the Ontario Drug Benefit Formulary as well as a number limited-use drugs, some nutritional products and some diabetes testing products.

The provincial government has recently established Local Health Integration Networks. The networks consists of fourteen local organizations that are responsible for planning, integrating and funding local health services, including hospitals, community care access centers, home care, long-term care, mental health, community health centers and community support services, to make it easier for patients to access the care they need.

The role of LHINs is to bring the management of healthcare delivery to the local level and enable the Ministry of Health and Long-Term Care to focus on providing stewardship to the system. This initiative from the government is part of a long-term plan whose priorities are to build a health care system that keeps Ontarians healthy, reduces waiting times and provides better access to doctors and nurses.

Healthcare Delivery Challenges in Ontario

The Supreme Court of Canada decision declaring illegal the prohibition on private health insurance in Quebec may well have repercussions in Ontario, where the general mood has been to strengthen the monopoly of Medicare rather than to weaken it. For example, Ontario's 2004 Commitment to the Future of Medicare Act (Bill 8) is aimed at strengthening the prohibition of "two-tier" medicine by closing legislative loopholes that allow queue-jumping and extra billing. These are issues that will have to be worked out in coming years.

Major Ontario hospitals, all of which are publicly funded, are in need of major upgrade. Through the Ministry of Health and Long-Term Care, the Ontario government is investing CDN $121 million to expand health care services in hospitals across Ontario in fifteen top priority specialties. Funds will be provided for modernizing and improving cardiac surgery, dialysis, hip and knee implants, trauma, magnetic resonance imaging (MRI), neonatal care, organ transplants, bone marrow transplants, acquired brain injury care, cleft lip and palate surgery, regional geriatric programs, maternal serum screening, cancer cytogenetics, sexual assault treatment centers and skin bank for reconstructive surgery. The funding includes, for example, approval for the acquisition of five new magnetic resonance imaging machines in the Toronto area and in London, as well as provisions for acquiring another five machines for in other areas of the province.

Additionally, bond issuances by Toronto hospitals will enable significant hospital modernization and expansion projects. The Toronto General Hospital, the Princess Margaret Hospital and the Toronto Western Hospital, under the umbrella of a new entity called the "University Health Network," have successfully raised CDN $300 million for projects such as the major reconstruction and renovation at the Toronto General Hospital and Toronto Western Hospital sites. Called Project 2003, this project will include new laboratory space, a new suite of 23 operating rooms, new intensive care rooms and a new seven-floor wing. Further plans include demolition of the Edith Cavell Wing with reconstruction of inpatient laboratories and a new ambulatory care wing. Further information on this project is available at: **http://www.uhealthnet.on.ca**.

Medicare and Healthcare Delivery in Quebec

Home to 7.6 million inhabitants (24 percent of the Canadian population), the province of Quebec is the second largest Canadian province. More than 80 percent of the population speaks French as their first language. Canada's lowest per-capita public and private health spending is in Quebec, with CDN $3,850

per person estimated for 2005. Healthcare accounted for about 30 percent of Quebec's budget in 2001-2002.

The Administration of Public Healthcare Delivery in Quebec

Tax-paid health care in Quebec is universally available to all residents at no separate cost to the patient. Quebec's Medicare plan, the Quebec Medical Health Insurance Plan, and the Public Prescription Drug Insurance Plan are administered by the (Régie de l'Assurance Maladie du Quebec): http://www.ramq.gouv.qc.ca/index_en.shtml. The Plan covers the full cost of all necessary diagnostic and treatment medical services including physician examinations, medical testing, emergency care, hospital care and emergency dental care.

Quebec's public healthcare delivery administration is at three levels: central (provincial), regional and local. At the provincial level is the Minister of Health and Social Services (Ministère de la Santé et des Services sociaux – MSSS). Its primary functions are to supervise and coordinate the provincial health system and to allocate financial resources based on fixed objective achievements. In its Strategic Planning for 2005-2010 (in French), the Ministry highlighted four selected strategies in the maintenance and enhancement of the population's health status. They include a problem-managing strategy through prevention and promotion, an improvement and a greater customization of primary health services and an improvement of the resources management and allocation.

The Régie de l'assurance maladie du Québec (RAMQ) is a branch of the ministry that applies and administers the insurance programs and other programs designated by the government. RAMQ counsels the ministry of health on the administration and application of its programs and develops strategies to reach its goals.

The regional level is composed of 18 regional health and social service agencies "Agences de la santé et des services sociaux," each responsible for the planning, resources management and financial allocation of their 18 districts in Quebec. Finally the local level, which was restructured in 2003, aims to provide multidisciplinary care through 95 local integrated networks, centered around centers for health and social services (Centre de santé et de services sociaux – CSSS) as well as more than 322 partners from the local services networks.

In total five broad types of institutions provide health and social services: the health and social services centers - CSSS (formed by the fusion of local centers for Community services – CLSC, with long-term care facilities), hospitals, long-term care facilities, re-adaptation facilities and centers for the protection of children and youth.

Healthcare Delivery Challenges in Quebec

The aging Quebec population will have a serious impact on the demand for healthcare services and the income taxes available to finance universal healthcare based on medical necessity. The proportion of people of more than 65 years old is expected to reach 27 percent by 2031. This will put pressure on the system to cut costs and develop additional methods of financing healthcare to avoid further rationing of healthcare through tighter appropriation limits resulting in the lengthening of already unpopular waiting times for healthcare service and treatment. The average age of nurses is also causing serious concerns. If all registered nurses were to retire at 55, slightly over half the nurse workforce would be lost by 2006.

Also, recruiting and retaining the right mix of care providers is an ongoing issue for Canada. Not only are today's doctors changing the mix of services they provide, but also younger physicians are seeing fewer patients than their same-aged peers did ten years ago. This has contributed to the long wait times to see a specialist, receive diagnostic tests or undergo elective surgery. As of 2004, doctors' fees account for a smaller portion of overall health spending than prescription drugs.

Over the next decade, healthcare delivery will have to focus on the causes of three-quarters of the deaths within Quebec: cancer, heart disease and respiratory ailments. Moreover, Quebec has the highest suicide rate in Canada, with an increase of almost 65 percent during the last 20 years, creating further challenges. Finally, outbreaks in Quebec hospitals of Clostridium difficile (C difficile), a bacterium causing severe and sometimes fatal diarrhea, and the outbreaks of SARS in 2003 and water-borne diseases in Ontario have put Canadian public health in the spotlight. In response to the latter crisis, the federal government established the Public Health Agency of Canada and announced a plan to create the new Health Protection and Promotion Agency by the end of 2005.

Implications For U.S. Business

The projects identified in this report and others that are anticipated offer substantial sales opportunities for U.S. providers of a wide range of medical equipment and technologies. Demand for medical equipment and supplies from the public sector network, is expected to grow across Canada over the next three years at a rate approaching 10 percent annually. Demand for imaging technologies continues to dominate the medical equipment scene in terms of growth while requirements for medical supplies have continued to increase for the prevention and control of infection. Because of a rapidly aging population, orthopedic devices including implants are products also expected to show a significant increase in demand. The Canadian market remains very strong and receptive to any new U.S. medical product presenting cost-efficiency and better care. Ontario and Quebec hospitals all buy non-Canadian medical products and equipment, provided that they meet Canadian Standards Association or Canadian Medical Association standards as required by provincial legislation.

U.S. companies interested in these opportunities need to acquaint themselves with how procurement will be handled. Procurement by hospitals in the major Ontario metropolitan areas such as Toronto and Ontario tends to be handled by the procurement office of one of the hospitals. For example, in Toronto, five major hospitals have centralized purchasing with the Toronto General Hospital. In contrast, hospitals in smaller cities handle their procurement individually.

Staying abreast of business opportunities in each Canadian province and territory is therefore important. While some companies may be able to do business directly from their U.S. offices, U.S. exporters new to the Canadian market may more wisely choose to appoint an agent or distributor to pursue market opportunities in Ontario and Quebec, Canada's two largest healthcare markets. More and more U.S. suppliers are finding success in this market through direct monitoring by their own representative on the ground if volume justifies or by forming a business relationship with a provincial, regional or national distributor to represent the U.S. company or distribute its products.

U.S. companies interested in pursuing business opportunities in Canada's healthcare market should consult with Pierre Richer, Senior Commercial Specialist, U.S. Consulate General Montreal, at 514-908-3661 or e-mail at pierre.richer@mail.doc.gov
concerning their market strategy. CS Canada offers a variety of resources and services including market research, agent/distributor searches, corporate matchmaking and other customized services to assist U.S. exporters of non-agricultural products entering new markets.

In particular, companies should consider utilizing the Gold Key Matching Service, which includes a market briefing and qualified appointments with potential partners, representatives, or end-users. Additional information on local market characteristics and business practices is also provided.

Anne-Marie Scherrer contributed to the research and drafting of this report.

For More Information

The U.S. Commercial Service in Montreal, Canada can be contacted via e-mail at: montreal.office.box@mail.doc.gov; Phone: (514) 398-9695 ext. 6-2220; Fax: (514) 398-0711 or visit our website: www.buyusa.gov/canada/en

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